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ABSTRACT

The object of this research is to determine if medical schools in the United States are offering death education. The study is basically reportorial. Rationale for the study and a review of selected literature are stated. An increased emphasis on death education in recent years is found both in the literature and the data presented here. The research instrument is a mailed questionnaire sent to the deans of the 113 medical schools in the United States. The return rate for this one-page questionnaire is 95 percent. Statistical analysis using the Chi square test of significance revealed no statistical difference between size of student body, regional location, and private or public school and whether or not death education is taught. The data show that only 14 of the 107 medical schools returning the questionnaire do not have "formal death education per se." The majority have "a lecture or two" or a "mini-course" while only seven have a full-term course. Death education in medical schools is new within the past decade and the emphasis within the curriculum is limited. In conclusion, suggested types of death education courses in medical schools are presented. (Author)

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DEATH EDUCATION IN MEDICAL SCHOOLS IN THE UNITED STATES*

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In the United States the subject of dying is similar to the subject of sex in that both, until very recently, were treated as taboo subjects. Contrary to many non-literate societies described in anthropological literature, socialization into the American way of life does not generally prepare one to cope with dying. Currently, dying takes place "off-stage" in that one often dies in an alien place such as a hospital where only a fraction of his life has been spent among persons with whom very little contact has been had within his lifetime.

Recently, however, more interest has been shown in death-related matters. Robert Fulton (1972:74), Director of the Center for Death Education and Research at the University of Minnesota, states, "In the last five years alone, more material on the subject has been published in scholarly and professional journals than had appeared in the previous 100 years." James Hollis (1975:24) states that over 400 high schools and many colleges and universities have courses on "thanatology." Since most deaths in the United States take place in a hospital or senior citizens' home, medical personnel such as physicians are in a strategic position to relate to dying patients.

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Objectives

It is the objective of this research endeavor to determine if medical schools in the United States are offering death education. The study is largely reportorial. The degree of emphasis on death education, the duration of such an emphasis, and the professional background of the instructor(s) are sought. Whether a statistically significant difference in death education emphasis exists between private and public medical schools, between geographical areas and size of the student body will be determined in this study. Suggested death education courses for medical school will be presented briefly.

Rationale and Selected Review of Literature

By reviewing the literature evidence exists to suggest that death education is needed in our society. A few excerpts from the literature follow.

> ...the care of the dying patient is complicated by many factors other than those usually considered, and we have for too long failed to study this important problem with the precision and compassion it deserves. (Lasagna, 1970:100)

According to Quint (1967), American nurses and staff physicians seem to find it difficult to carry on conversations about death or dying with patients. Perhaps one of the more widely-read accounts concerning the need for more death education for medical personnel in our society is Elizabeth Kubler-Ross's Death and Dying (1969). Other sources address themselves to this need:

> Medical education has, traditionally, offered little

> help to the medical student encountering death for the first time. In fact, discussion of death is conspicuous by its absence. 'Death is not even found in the indexes of most medical and surgical textbooks, nor can I recall any discussion in medical school concerning the consequences of death for the physicians.' (Rabin, 1970:172)

Harry Olin (1972:564) states that death is a powerful source of emotion for the medical student and can strongly influence his care of a dying patient. For many students the first exposure to death and dying is an impersonal experience and takes place in an anatomy laboratory. Olin adds that experience with a cadaver is not adequate to prepare the beginning student to deal with the highly charged event of death to which he will be exposed.

Dumont and Foss' The American View of Death (1972) stresses that the individual American receives very little guidance in forming his attitudes toward death either from his parents or from his society. Thus, one is dependent upon his own individual experiences with death and dying in learning to cope with these issues.

Robert Neale in The Art of Dying (1973:10) states:

> The doctor is trained to work with bodies; very rarely is he trained to work with people, to understand and aid a personality. Medical school discussions on the dynamics of the dying are almost always limited to ways to get permission for surgery and autopsy. So it is understandable that a doctor frequently becomes extremely uncomfortable in the presence of a dying patient and retreats to his habitual clinical objectivity.

Neale's argument is given support by David Barton (1972:170), a psychiatrist from Vanderbilt University, who states:

> Physicians' attitudes toward death are reflected in the paucity of formal instruction about the subject in the medical school curriculum. While some instruction about the topic occurs, most of this is given in an indirect and often evasive manner, is impersonal (for example, informing students how to obtain autopsy permits), takes place at times of crisis, or is presented in the form of lectures or presentations by learned panelists. These types of instruction fail to allow effectively the students to 'work through' their individual attitudes toward death and dying to achieve a therapeutically useful synthesis of their feelings.

Kasper (in Feifel's The Meaning of Death, 1959:266) suggests that when a physician visits his dying patient, he faces his own helplessness. He states, "I submit that it is no wonder psychiatrists say little can be done with dying patients; it is true, but I suspect it is not the fault of the dying patient."

A. L. Wheeler (1973:49) found from his study in the southeastern United States that only 13 of the 81 physicians in his sample indicated that they had any formal education in the management of dying patients. Of these 13, only 6 reported having had an entire course devoted to the problem.

Methodology

A questionnaire with closed-ended questions and a few open-ended questions accompanied by an explanatory cover letter was mailed to the deans of the 113 medical schools in the United States on April 14, 1975. Follow-up notices were sent to non-respondents on May 19 and June 6. A total of 107 questionnaires (95 percent) were returned.

The one-page mailed questionnaire sought to ascertain the following

information: number of students enrolled, private or public institution, type of death education offered, number of years offered, percentage of students involved, professional background of instructor(s), and plans for future offerings.

Independent variables are: size of student body, regional location of the medical school, and whether the school is private or public. The dependent variable is whether or not death education is taught. For statistical analysis the Chi-square test of significance is used. The .01 level of significance is used for determining statistical significance.

Findings

Of the 107 medical schools responding to the questionnaire, 41 are private institutions and 66 are public. The average annual enrollment is 462.

The data show that only seven medical schools of the 107 responding have a full-term course in death education. However, 44 schools have a "mini-course" and 42 have "a lecture or two" on death education. Only 14 schools have no formal death education per se. Thus, while death education exists in the curriculum of the majority of medical schools in the United States, the emphasis on such education is limited.

Death education is relatively new to the medical school curriculum in the United States as 73 percent of those reporting some kind of death education have had such for less than five years. Only five percent have included death education in their curriculum for ten years or more.

With the majority of United States medical schools having at least "a lecture or two" on death education, these data show that 71 percent

of the schools require that at least half of their students be exposed to this part of the curriculum. Thus, many medical students are apparently graduating with very limited formal death education.

Of the 93 schools offering something in death education, the approach of 55 schools is to use a team effort with instructors being from various disciplines. In response to the question concerning the professional background of the death education instructor(s), the results were: medical doctor 79, theologian 43, psychologist 34, sociologist 24, psychiatrist 12, nurse 7, philosopher 5, social worker 4, lawyer 2, and literature 1. A multi-disciplinary approach, therefore, tends to be stressed for the majority of medical schools.

The 14 schools responding that "no formal death education per se" is offered indicated that death education is in the plans for over half of them with two stating that death education will be in the curriculum "within the next year" and for six "within the next five years." Six schools have no plans for death education in the curriculum in the future.

No statistically significant difference was found when relating geographical region, private or public institution, or enrollment to the dependent variables of death education offering, duration of the offering, and percent of students taking death education. Thus, no difference in death education emphasis in medical schools exists between regions of the United States, between private and public institutions, or by enrollment of students, according to this study.

Conclusions

These data support Robert Fulton's comment that interest in death education has increased considerably within recent years. However, the

majority of medical schools in the United States today tend to be giving only a limited amount of emphasis to death education. Two respondents stated that their schools have no death education due to "no time in the curriculum." Responding to such claims, Harry Olin (1972:566) suggests that a student may be taught about diseases so rare that his personal experience with these diseases would be necessarily limited. Olin asks if dying does not represent for the clinician a serious clinical condition and a highly frequent one?

One medical doctor informed the author that relating to dying patients cannot be taught by instruction but can only be learned "on the job." Olin (1972:564) states that what actually is acquired or reinforced in many students "on the job" is an attitude that serves defensively to maintain an emotional distance between them and dying patients.

If death education emphasis in medical schools of the United States continues to increase, what format might courses take? Several suggestions are given by respondents and the literature. James Hollis (1975:24) describes a multi-disciplinary exposure with numerous reading assignments in a death education course in which students are engaged at the affective level after being instructed to the intellectual and imaginative ways in which humans have confronted mortality. It is Hollis' assertion that the student of death education will no longer find the contemplation of mortality a morbid and useless exertion.

Duncombe (1974), a Yale University Medical School chaplain, has offered a seminar on the chronically ill for the past six years. His course has a limited amount of reading material and is based on three

assumptions: (1) students should know more about the sick person's world; (2) knowledge of this sort is best taught by the sick person; and (3) students must enhance each other's discussion and interpretation when they are from different professional backgrounds. Thus, his multi-disciplinary approach involves divinity, medical, law, nursing, and public health students who meet weekly with their supervisors to discuss their association with dying patients.

David Barton (1972), a psychiatrist at Vanderbilt University School of Medicine, prefers the small group interdisciplinary discussion technique to allow the student to hear varying attitudes and to move toward a synthesis of his own feelings and overcome the traditional avoidance of the topic of death and dying. He suggests inclusion of death instruction at all levels in the medical school curriculum. Barton, et al. (1972:945) adds that student attention needs to be directed toward the many psychosocial dimensions of life-threatening illness and the death situation.

The model to follow in teaching medical students to relate to dying patients already exists, according to Harry Olin (1972). He suggests that first-year medical students be assigned the family of a dying patient much as they are assigned in some medical schools to a family in which the mother is about to deliver. He proposes that the human process of dying - the ending of life - could be taught in a similar setting to the human prodess of birth - the beginning of life. The first-year class would be divided into groups of four to six students who would meet regularly with an instructor. Through review of the medical literature on the subject of dying and through interviews with

dying patients, the student would have exposure to dying along with some "share sessions" with peers and an instructor. The students' main contribution, according to Olin, would be to make the patient feel comfortable enough to talk about what troubles him.

In summary, current death education courses tend to follow a multi-disciplinary approach with small groups of fewer than ten students, one or two supervisors, and the dying patient. All interact with each other at regular intervals. The goal of these courses is to allow the student to work through his own attitudes toward death and dying in order to be more sensitive to the needs of his patients. Granted, a death education course within the medical curriculum is time consuming. However, in considering the significance of dying within the human experience, medical educators might want to weigh the value of incorporating such a course into their curriculum. If society were better prepared to cope with dying, the dying process might not be the awkward experience it is for many today. The curriculum of the medical school could be a very significant beginning point for more structured death education in the United States.

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DEATH AND DYING QUESTIONNAIRE

PART I

1. Medical school from which you received your degree: _____
2. Medical specialization: _____
3. While in medical school, which of the following typified your formal instruction on the subject of relating to dying patients and their families:
   _____ an entire course devoted exclusively to the subject
   _____ portions of other courses devoted to the subject
   _____ no formal instruction in the subject

   If you had an entire course, it was:

   a. _____ required
      _____ an elective

   b. _____ taught by lecture
      _____ a discussion group
      _____ an informal tutoring in the ward around patients under study
      _____ other, please specify:
      _____
      _____
4. Undergraduate school from which you received your degree: _____
5. Undergraduate major: _____
6. Sex: _____ male _____ female

PART II

Eleven statements primarily concerning your feelings and reactions toward dying persons follow. There are five blanks below each statement for you to indicate your level of agreement with the statement. Please check the blank that best describes your own opinion.

1. When one of my patients dies, I always wonder if something could have been done to save him.
   Strongly agree ___ Agree ___ Neutral ___ Disagree ___ Strongly disagree ___

2. I feel as comfortable with a dying patient as I do with any other patient.
   Strongly agree ___ Agree ___ Neutral ___ Disagree ___ Strongly disagree ___

3. I do not think about death very much.
   Strongly agree ___ Agree ___ Neutral ___ Disagree ___ Strongly disagree___

4. Treating a dying patient is one of the most unpleasant aspects of my profession.
   Strongly agree ___ Agree ___ Neutral ___ Disagree ___ Strongly disagree ___

5. Whenever possible, I avoid a person who is dying from an irreversible condition.
   Strongly agree ___ Agree ___ Neutral ___ Disagree ___ Strongly disagree ___

6. I try to avoid telling a patient directly that he is dying.
   Strongly agree ___ Agree ___ Neutral ___ Disagree ___ Strongly disagree ___

7. I find it more difficult to deal with the family of a dying patient than with families of my other patients.
   Strongly agree ___ Agree ___ Neutral ___ Disagree ___ Strongly disagree ___

8. A patient's death does not depress me when I know there was nothing I could do to save him.
   Strongly agree ___ Agree ___ Neutral ___ Disagree ___ Strongly disagree ___

9. Telling a person he is going to die is difficult for me.
   Strongly agree ___ Agree ___ Neutral ___ Disagree ___ Strongly disagree ___

10. I believe physicians refer terminal patients to other physicians more often than nonterminal patients in order to avoid having to deal with their dying.
    Strongly agree ___ Agree ___ Neutral ___ Disagree ___ Strongly disagree ___

11. I think it is essential that a dying patient be told of his prognosis.
    Strongly agree ___ Agree ___ Neutral ___ Disagree ___ Strongly disagree ___

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